DerMANtology 101:

Common Skin Problems Seen in Men

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There are many skin and hair issues for which men will commonly consult their physician. To test your knowledge, here are some cases spanning common dermatological conditions with male predilection.

Case 1: "Why am I losing my hair?"

A 35-year-old man has noticed gradual thinning and shedding of hairs along his frontal scalp (Figure 1). His father underwent similar hair loss, but is now completely bald on the top of his head. He is wondering about therapies that can prevent a similar fate.

Q: What is this pattern of hair loss? Can we prevent further hair loss?

Figure 1. Thinning hair.

Q&A *"Why am I losing my hair?"*

What is this pattern of hair loss?

Androgenetic alopecia (AGA), or male pattern baldness, is the most common form of hair loss, affecting 50% of males.[1] This is most marked after age 40, but may begin after puberty. Its etiology includes genetic predisposition and androgenic effects of dihydroxytestosterone (DHT). The most common male pattern is a receding M-shaped hairline in the parietal scalp and later thinning of the vertex.

Can we prevent further hair loss?

AGA may be treated through a number of modalities:

- Topical 2% to 5% minoxidil
- Oral finasteride and other antiandrogens
- Surgical hair transplantation

Cosmetic camouflage with wigs and toupees can mask areas of AGA.

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Case 2: "Can you help me control my sweating?"

A 28-year-old businessman complains of excessive sweating in his axillae, which is annoying in social and business situations (Figure 2). This has been a problem since childhood and he was wondering about possible therapies.

Q: What is this condition called? How can we help him?

Figure 2. Excessive sweating.

Hyperhidrosis is the term given to excessive sweating. Although an estimated 2.8% of the population suffers from this condition, only 38% realize it can be treated and consult their physician.

Q&A *"Can you help me control my sweating?"*

What is this condition called?

Hyperhidrosis is the term given to excessive sweating. Although an estimated 2.8% of the population suffers from this condition, only 38% realize it can be treated and consult their physician.[2] It most commonly affects the axillae, palms and soles due to their high concentration of sweat glands. Hyperhidrosis is classified as either generalized or localized, the latter being more common. Generalized hyperhidrosis may result from internal factors (*i.e.*, genetic, metabolic, tumours, drugs) and is often exacerbated by warm temperatures, anxiety, spicy food and caffeine. In contrast, localized hyperhidrosis is usually unrelated to internal factors or physical stimuli.

How can we help him?

Medications that help control localized hyperhidrosis include:

- Topical dessicating preparations (*e.g.*, antiperspirants containing aluminum hydroxide)
- Botulinum toxin A injections. This treatment is far superior as it controls autonomic nerve conduction and therefore reduces the rate of sweating early in the production pathway

Surgery in the form of central or peripheral sympathectomy may be helpful in severe cases, but should be reserved for only the most refractory cases.

Case 3: "Doc, is this a STD?"

A 46-year-old man presents with a 3-month history of well-demarcated, scaly red lesions on the glans penis (Figure 3). He is worried that this might have been contracted after sexual intercourse with a new partner. On physical examination, a similar lesion is noted on the left elbow.

Q: What is the most likely diagnosis and treatment?

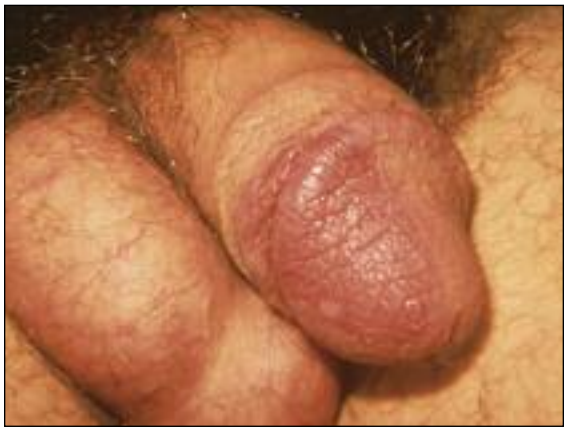

Figure 3. Scaly red lesions on the glans penis.

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"Doc, is this a STD?"

What is the most likely diagnosis and treatment?

Psoriasis is in fact, the most common inflammatory dermatosis of the male genitalia. Due to location, patients are often worried that they have contracted a STD. Penile psoriasis usually presents as erythematous, well-defined plaques with thin scale on the glans, corona or under the prepuce. The penis may often be the only presenting site, but plaques may also be found on extensor surfaces or scalp, as well as pitting or uplifting of the nail plate. Friction due to sexual intercourse may exacerbate these lesions.

Penile psoriasis responds well to mid-potency topical corticosteroids (*e.g.*, mometasone furoate). High-potency corticosteroids should be avoided to prevent atrophy of delicate genital skin. Vitamin D derivative creams (*e.g.*, calcipotriol) may be used as a steroid alternative. Reduction of aggravating factors through abstinence, condom and lubricant usage may stop plaques from developing.

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Case 4: "Should I have worn shoes?"

An 18-year-old male college student who recently moved into his new dorm presents with a 2-week history of itchy, damp white plaques between the fourth and fifth toes on his right foot (Figure 4).

Q: What is happening to his foot and how can we help?

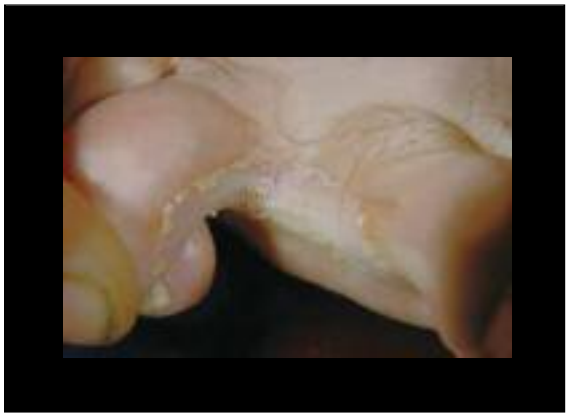

Figure 4. Damp white plaques between toes.

Tinea pedis, better known as athlete's foot, is the most common fungal infection, affecting 15% of the population.[3]

Q&A *"Should I have worn shoes?"*

What is happening to his foot and how can we help?

Tinea pedis, better known as athlete's foot, is the most common fungal infection, affecting 15% of the population.[3] Trichophyton rubrum and *T. mentagrophytes* are the most common causative organisms. This infection frequently occurs interdigitally in toe webspaces, where lesions are moist and macerated. Elsewhere on the foot, lesions are dry, scaly, poorly-demarcated plaques. Tinea pedis is usually unilateral, but may become bilateral.

A number of antifungal agents may be used to treat tinea pedis, including:

- Topical terbinafine
- Topical imidazoles (*e.g.*, ketoconazole)
- Topical pyridones (*e.g.*, ciclopirox)
- Oral antimycotics (*e.g.*, terbinafine, itraconazole)

The patient may also be counselled to avoid occlusive footwear, keep feet dry with foot powders and wear protective footwear around communal areas. Dx

References

1. Hamilton JB: Male Pattern Hair Loss in Man: Types and Incidence. Ann N Y Acad Sci 1951; 53(3):708-28.
2. Strutton DR, Kowalski JW, Glaser DA, et al: US Prevalence of Hyperhidrosis and Impact on Individuals with Axillary Hyperhidrosis: Results from a National Survey. J Am Acad Dermatol 2004; 51(2):241-8.
3. Bell-Syer SE, Hart R, Crawford F, et al: Oral Treatments for Fungal Infections of the Skin of the Foot. Cochrane Database of Systematic Reviews 2002; (2):CD003584.